# DEPARTMENT OF HEALTH AND HUMAN SERVICES

PRINTED: 05/31/2019 FORM APPROVED

CENTER	S FOR MEDICARE &	MEDICAID SERVICES				OMB NO	0. 0938-0391
	DF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING  B. WING		(X3) DATE SURVEY COMPLETED	
		10L001	B. WING				C 08/2019
	ROVIDER OR SUPPLIER PALMS ACADEMY		•	592	REET ADDRESS, CITY, STATE, ZIP CODE 25 MCKINLEY STREET DLLYWOOD, FL 33021		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC (DENTIFYING INFORMATION)		ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD TAG CROSS-REFERENCED TO THE APPROP DEFICIENCY)		BE	(X5) COMPLETION DATE
N 000 Initial Comments			N	000			
	Number 2019007757 2019007761, was co Florida Palms Acade Treatment Facility. The facility is not in c Federal Regulations Subpart G, Condition Residenti One Condition level of	my, a Residential  ompliance with Code of  (CFR) 42, Part 483.354  of Participation for  al Treatment Facilities.  deficiency was identified to  at 42 CFR Part 483.350					
N 100	Fourteen Standard le identified to be out of N0149, N0151, N015, N0165, N0165, N0165, N0196.  The effect resulted in the Facility's inability to a would be met.		z	100			
	of and Residential Treatmen	Services for Individuals					
		not met as evidenced by: he Residential RTFYs Policies and					

Any deficiency statement ending with an asteriak (1) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclossable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclossable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued prooram participant.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

(X6) DATE

FORM APPROVED
OMB NO. 0938-0391
(X3) DATE SURVEY

		ID HUMAN SERVICES			FOR	RM APPROVED
TATEMENT O	S FOR MEDICARE & I OF DEFICIENCIES CORRECTION	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTI	PLE CONSTRUCTION G	(X3) DA3	IO. 0938-0391 E SURVEY IPLETED
		10L001	B. WING		C 05/08/2019	
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD 5925 MCKINLEY STREET	E	
FLORIDA	PALMS ACADEMY			HOLLYWOOD, FL 33021		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
N 100	Procedures, record re determined the PRTF Ensure a physician's by a physician's by a physician's by a physician's consider and emergency safety intended to order and emergency safety intended to the process of the pr	eview and interview, it was failed to:  order was obtained for a in, or other licensed by the state and the facility trained in the use of eventions (N0140), assessment of the physical li-being of the resident was our of the initiation of the evention by a physician, or oner trained in the use of eventions (N145), and the intervention in the end of the shift, in which is (N149), attorned to the time the evention actually began and attorn of the time and results assessment (N152), attorned the resident to be attorned the record of each ration, the interventions actually began and actually began and attorned the resident to be attorned to the resident to be attorned the resident to be attorned to the resident to be attorned to the record of each ration, the interventions	N 11			
	emergency safety into present, continually a	erventions physically ssessing, and monitoring well-being of the				

the duration of the emergency safety intervention

Ensure a physician, or other licensed practitioner

		ID HUMAN SERVICES MEDICAID SERVICES			FORM	APPROVED 0.0938-0391	
STATEMENT C	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		10L001	B. WING _		05/	08/2019	
NAME OF PR	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE			
FLORIDA	PALMS ACADEMY			5925 MCKINLEY STREET HOLLYWOOD, FL 33021			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)			
N 100	the resident's well-be mergency safety intresident's well-being in service of the safety intresident's well-being in service of the safety resident (N188). Ensure a debriefing sincludes a review and mergency safety sit intervention, including necepitating factors it within 24 hours after staff involved in the eintervention, and applications to the safety of the sa	and the facility to evaluate ing and trained in the use of averventions, evaluate the immediately after the N167), discussion within 24 hours with staff involved in intervention and the ession was conducted that discussion of the aution that required the gliscussion of the attending the intervention he use of with all mergency safety opriate supervisory and 1189), attending the the second section of the resident's record essions took place and mentation the names of staff the debriefing, names of ed from the debriefing, and scident's treatment plan that fings (N193) and ment was immediately directical personnel for a result of an emergency	N1	00			
N 140	ORDERS FOR USE	OF OR	N 1	40			

CFR(s): 483.358(a)

# PRINTED: 05/31/2019 FORM APPROVED DEPARTMENT OF HEALTH AND HUMAN SERVICES

ENTERS FOR MEDICARE & MEDICAID SERVICES 0									
ATEMENT OF DEFICIENCIES ID PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING	(X3) DATE SURVEY COMPLETED						
	10L001	B. WING	С						
	10001	D. 10119G	05/08/2019						

		10L001	B. WING _	_		05/08/2019	
NAME OF P	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
			l		5925 MCKINLEY STREET		
FLORIDA	PALMS ACADEMY				HOLLYWOOD, FL 33021		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC (DENTIFYING INFORMATION)		ID PREFID TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	Ę	(X5) COMPLETION DATE
N 140	Orders for or or physician, or other list of the State and the from the services for beneficial provided under the distribution of the services for beneficial provided under the distribution of the services for beneficial provided under the distribution of the services for beneficial provided under the distribution of the services o	must be by a mean must be by a mean paracitioner permitted acility to order or in the use of emergency rederal regulations at 42 that inpatient, ries under are rection of a physician.  not met as evidenced by: not not met as evidenced by: not	N 3	1440			

		F	^	0	N A	١ ٨	5	SE:	-	0	'n	/C	31	-
		4.	v	n	W		١r	-	r		"	r c	= 1	-
c	ı	νtΒ	. 1	NI	7	- 1	30	ar	2		3	20	۵	1

		ID HUMAN SERVICES MEDICAID SERVICES					M APPROVED 0. 0938-0391
STATEMENT (	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			SURVEY PLETED
		10L001	B. WING				08/2019
NAME OF P	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE	,	
					5925 MCKINLEY STREET		
FLORIDA	PALMS ACADEMY				HOLLYWOOD, FL 33021		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
N 140	snack, no problems di medication with no problems di medication with no problemore di medication with no problemore. No problemore di medication della medication della medication della medicationa della medicat	uring mealtime. Took their oblem. Had positive, interacted well with peers, iff direction, had appropriate am behaviors during shift, so the Nursing Office and restrained by staff last night, eals there was no evidence report of 1's record lacked any ion that a physician's order as required. Cet on at 2:21 PM, fanager stated she was if the incident, was not at irrection to the Supervisors is no "Packet" ecause it was not completed licy, cated on at 2:53 PM, sed Practical Nurse) stated iden and they sent ceted on at 2:09 PM,	N	114			
	called her and told he instructed her to take and "I'm on my way. I arrived at the facility,	ight before, 3 times. Staff D ir about Resident #1, the resident to "Nursing" and another Manager interviewed Staff A who ained the resident but didn't					

call it in or notify anyone." A review of the facility's document titled

DEPARTMENT OF HEALTH AND HUMAN SERVICES							
CENTERS FOR MEDICARE & MEDICAID SERVICES O							
ATEMENT OF DEFICIENCIES ID PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING	(X3) DATE SURVEY COMPLETED				
	10L001	B. WING	05/08/2019				

				_		05/08/2019
NAME OF P	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE	
					5925 MCKINLEY STREET	
FLORIDA	PALMS ACADEMY				HOLLYWOOD, FL 33021	
(X4) ID PREFIX TAG	(EACH DEFICIENC	SUMMARY STATEMENT OF DEFICIENCIES ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) TAG			PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETIO DATE
N 140	"Correspondence" da during morning 15-mi Hallway," on that Resident #1 had	ted revealed, nute checks of "North Staff E noticed visible red marks to the 1 stated Staff A restrained	N	140		
N 145	him three times last n F, advising her of the Resident #1 three tim	ight. Staff A contacted Staff incident taking place on Staff A, stated, "I restrained es last night."	N	148	9	
	safety intervention a practitioner trained in safety interventions a and the facility to ass wellbei conduct a -to-physical and , resident, including bu	ng of residents, must assessment of the wellbeing of the				
	measures; and  (4) Any complication intervention.  This ELEMENT is not Based on review of the Treatment Facility (Plant).	oness of the intervention ons resulting from the t met as evidenced by: ne Residential				

## PRINTED: 05/31/2019 DEPARTMENT OF HEALTH AND HUMAN SERVICES

10L001		B. WING	05/08/2019				
			С				
ATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING	(X3) DATE SURVEY COMPLETED				
ENTERS FOR MEDICARE & MEDICAID SERVICES O							
DELAKTING TO THE ACTION OF THE							

						С		
		10L001	B. WING			05/08/2019		
NAME OF P	ROVIDER OR SUPPLIER			ST	FREET ADDRESS, CITY, STATE, ZIP CODE			
				59	25 MCKINLEY STREET			
FLORIDA	PALMS ACADEMY			HOLLYWOOD, FL 33021				
	CURANA DV CT	ATEMENT OF DEFICIENCIES		-	PROVIDER'S PLAN OF CORRECTION			
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		PREFIX TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATI DEFICIENCY)	(X5) COMPLETK DATE	N.	
N 145	Continued From page	6	N 1-	45				
	PRTF failed to follow	their own policies and						
	procedures and cond							
		ysical and						
		dent, within one hour of the						
		by a licensed practitioner for						
	1 of 3 sampled reside							
	The findings included	:						
	Record review of the	facility's policy titled						
		al						
		on , reveals that the						
		is limited to emergencies						
		inent risk of an individual						
		mself, staff or others, and						
		tions would not be effective						
		our of the initiation of a						
	a Physician,	Registered Nurse (RN) or				}		
		Nurse Practitioner (ARNP)				1		
	must conduct a -1	to- assessment of the						
	physical and	well-being of the						
	resident.	•						
	Record review reveal	s Resident #1 was admitted						
	to the facility on	and discharged on						
	with diagnoses that m	nade the resident eligible for						
	the program. A review	v of Resident #1's record						
	revealed documentati	ion that on on the						
	3:00 PM-11:00 PM "N	Mental Health Technician						
	(MHT) Shift Note," Re	esident #1 showered,						
	brushed their , a	te 100% of their meal and						
		luring mealtime. Took their						
	medication with no pr							
		, interacted well with peers,						
	followed rules and sta	aff direction, had appropriate						
	boundaries. No proble	em behaviors during shift.						
	No safety precautions	s during shift.						
		record revealed "Nursing						
	Notes," dated	at 2:09 PM revealing that						

Resident #1 came into the Nursing Office and

		ID HUMAN SERVICES MEDICAID SERVICES					APPROVED 0. 0938-0391
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL	TIP	PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
HOND PLUN OF	CORRECTION	IDENTIFICATION NUMBER:	A. BUILD	ING	š	COMP	TETED
						(	С
		10L001	B. WING	_		05/	08/2019
NAME OF PR	ROVIDER OR SUPPLIER			Г	STREET ADDRESS, CITY, STATE, ZIP CODE		
				1	5925 MCKINLEY STREET		
FLORIDA	PALMS ACADEMY				HOLLYWOOD, FL 33021		
-	0.0000000000000000000000000000000000000	AND WAR OF BUILDING		_			
(X4) ID PREFIX		ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL	ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE			(X5) COMPLETION	
TAG		SC (DENTIFYING INFORMATION)	TAG		CROSS-REFERENCED TO THE APPROPRIA		DATE
			-		DEFICIENCY)		
					4		
N 145	Continued From page	7	N	14	15		
	etated that they were	restrained by staff last night.					
		eals there was no evidence					
	of documentation of a						
	Review of Resident #						
		tation that ato-					
	assessment of the ph						
		dent within one hour of the					
		ov a licensed practitioner					
	was completed as rec						
	In an interview condu						
		Manager stated she was					
		of the incident, was not at					
		irection to the Supervisors					
	and stated that there						
		ecause it was not completed					
	as per the PRTF's po						
	In an interview condu	cted on at 2:53 PM,					
	Staff G, a LPN (Licen	sed Practical Nurse) stated					}
	she assessed the res	ident on , called the					1
	Nurse Manager and t						{
	the resident to the						
	In an interview condu						
	Staff F, Floor Manage	er states the incident					
	happened on	on the 3:00 PM-11:00 PM					
	shift, Resident #1 rep	orted to Staff E, that Staff A,					
	restrained them the n	ight before, 3 times. Staff D					
	called her and told he	r about Resident #1,					
	instructed her to take	the resident to "Nursing"					
	and "I'm on my way. I	and another Manager					
	arrived at the facility,	interviewed Staff A who					
	admitted that he restr	ained the resident but didn't					
	call it in or notify anyo	one."					
	A review of an undate	ed "correspondence," from					
		ered Nurse) working on					
	, stating that	there was no report of client					
		cidents on the 3:00					
	PM-11:00 PM shift on	to the Nursing					

Department by Staff A. A review of the facility's document titled

Facility ID: RC57000049P

## PRINTED: 05/31/2019 DEPARTMENT OF HEALTH AND HUMAN SERVICES

DEPARTMENT OF HEALTH AND HUMAN SERVICES							
CENTERS FOR MEDICARE & MEDICAID SERVICES CO.							
ATEMENT OF DEFICIENCIES ID PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING	(X3) DATE SURVEY COMPLETED				
	10L001	B. WING	05/08/2019				

				0010012010	
NAME OF PROVIDER OR SUPPLIER		T	STREET ADDRESS, CITY, STATE, ZIP CODE		
51 ODID 4	DAV MO A DADENY		5925 MCKINLEY STREET		
FLORIDA	PALMS ACADEMY	- 1	HOLLYWOOD, FL 33021		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
N 145	Continued From page 8  "Correspondence" dated revealed, during morning 15-minute checks of "North Hallway," on Staff E noticed that Resident #1 had visible red marks to the and Resident #1 stated Staff A contacted Staff F, advising her of the incident taking place on Staff A, stated, "I restrained Resident #1 three times last night."  ORDERS FOR USE OF OR  CFR(s): 483.356(n)  Staff must document the intervention in the resident's record. That documentation must be completed by the end of the shift in which the intervention corus. If the intervention corus not	N 1	45		
	end during the shift in which it began, documentation must be completed during the shift in which it ends. Documentation must include all of the following:  This ELEMENT is not met as evidenced by: Based on review of the Residential Treatment Facility (PRTF)'s Policies and Procedures, record review and interview, the PRTF failed to follow their own policies and				
	procedures to document a by the end of the shift in which it occurred for 1 of 3 sampled residents (Resident #1).  The findings included:  Record review of the facility's policy titled, "				

DEPART	MENT OF HEALTH AN	ID HUMAN SERVICES				FORM	M APPROVED
CENTERS FOR MEDICARE & MEDICAID SERVICES						OMB NO. 0938-0391	
	DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		PLE CONSTRUCTION  3		PLETED
		10L001	B. WING	_		1	C 08/2019
NAME OF PR	ROVIDER OR SUPPLIER			Γ	STREET ADDRESS, CITY, STATE, ZIP CODE		
					5925 MCKINLEY STREET		
FLORIDA	PALMS ACADEMY				HOLLYWOOD, FL 33021		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)		(X5) COMPLETION DATE
N 149	physically harming his non-physical interven and that staff docume by the end of the shift the order, the time the ended, the time and or assessment, the eme required the resident name of staff involves intervention. Record review reveal to the facility on with diagnoses that or the program. A review revealed documental 3:00 PM-11:00 PM 1% (MHT) Shift Note. Re brushed their a snack, no problems of medication with no problems of medication with no problems of safety precautions. No problem so safety precautions of the Notes," dated Resident #1 came int stated that they were of documentation of a Review of Resident #1 came int stated that they were of documentation of a Review of Resident #1 came int stated that they were of documentation of a Review of Resident #1 came int stated that they were of documentation of a Review of Resident #1 came int stated that they were of documentation of a Review of Resident #1 came int stated that they were of documentation of a Review of Resident #1 came int stated that they were workers that the evidence that the	ment risk of an individual mself, staff or others and titons would not be effective into should not be effective in which occurred; is not be restrained and the to be restrained and which on the on the on the discharged on made the resident et aligned for on the on the festione staff in the staf	Z	114	19		
	the Staff I. Program A	fanager stated she was	1				1

notified immediately of the incident, was not at the facility but gave direction to the Supervisors

		ID HUMAN SERVICES MEDICAID SERVICES			FOR	D: 05/31/2019 M APPROVED D: 0938-0391
	F DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIS A. BUILDIN	PLE CONSTRUCTION  G	COMP	SURVEY PLETED
		10L001	B. WING			C /08/2019
NAME OF PE	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
			1	5925 MCKINLEY STREET		
FLORIDA	PALMS ACADEMY			HOLLYWOOD, FL 33021		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE
N 149	and stated that there available for review b as per the PRTF's po in an interview condu. Staff G. a LPN (Licen she assessed the res Nurse Manager and the resident to the in an interview condu Staff F. Floro Manage happened on shift, Resident #1 rep restrained them the n called her and told he instructed her lot lake and "I'm on my way. I arrived at the facility, admitted that he rest call it in or notlity any. A review of the facility, admitted that he rest call time of the facility and the staff of the staff of the facility and the facility an	is no "Packet" eccuse it was not completed licy.  cted on at 2.53 PM, sed Practical Nurse) stated ident on called the he and they sent cted on at 2:09 PM, er states the incident on the 3:00 PM-11:00 PM orted to Staff E, that Staff A light before, 3 times. Staff D ir about Resident if Nursing" tand another Manager interviewed Staff A who aimed the resident to "United the ted revealed, unter the staff A letter of the staff A revealed, unter checks of "North Staff E noticed visible red marks to the 1 stated Staff A restrained light. Staff A contracted Staff incident taking place on Staff A, stated, "I restrained let lest jated place on Staff A, stated, "I restrained else I sat sight."	N 12	19		
	CFR(s): 483.358(h)(2	)				
	(Documentation must	include) the time the				1

emergency safety intervention actually began and ended.

### PRINTED: 05/31/2019 DEPARTMENT OF HEALTH AND HUMAN SERVICES ST

JEPARTMENT OF HEALTH AN	FORM APPROVED					
ENTERS FOR MEDICARE & MEDICAID SERVICES (						
ATEMENT OF DEFICIENCIES D PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING	(X3) DATE SURVEY COMPLETED			
			С			
	10L001	B. WING	05/08/2019			

NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE

5925 MCKINLEY STREET FLORIDA PALMS ACADEMY HOLLYWOOD, FL 33021 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID COMPLETION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE DATE TAG REGULATORY OR LSC IDENTIFYING INFORMATION). TAG CROSS-REFERENCED TO THE APPROPRIATE

N 151

DEFICIENCY)

N 151 Continued From page 11

AN

This ELEMENT is not met as evidenced by: Based on review of the Residential Treatment Facility (PRTF)'s Policies and Procedures, record review and interview, the failed to follow their own policies and procedures to document the time a actually began and ended, by the end of the shift in which it occurred for 1 of 3 sampled residents (Resident

The findings included:

Record review of the facility's policy titled, and Manual Policy," dated and revised on ... .. reveals that the use of manual is limited to emergencies in which there is imminent risk of an individual physically harming himself , staff or others, and non-physical interventions would not be effective and that staff documents the following information by the end of the shift in which .... . occurred; the order, the time the intervention began and ended, the time and results of the ...-to-... assessment, the emergency situation that required the resident to be restrained and the name of staff involved in the emergency safety intervention.

Record review reveals Resident #1 was admitted to the facility on .... and discharged on with diagnoses that made the resident eligible for the program. A review of Resident #1's record revealed documentation that on on the 3:00-11:00 PM Mental Health Technician (MHT) Shift Note, Resident #1 showered, brushed their , ate 100% of their meal and snack, no problems during mealtime. Took their medication with no problem. Had positive behaviors during shift, interacted well with peers, followed rules

and staff direction, had appropriate boundaries.

		ID HUMAN SERVICES MEDICAID SERVICES				FOR	D: 05/31/2019 M APPROVED D: 0938-0391
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		E CONSTRUCTION		PLETED
		10L001	B. WING			1	C (08/2019
NAME OF P	ROVIDER OR SUPPLIER	•			STREET ADDRESS, CITY, STATE, ZIP CODE		
				!	5925 MCKINLEY STREET		
FLORIDA	PALMS ACADEMY			۱	HOLLYWOOD, FL 33021		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE
N 151	C#	. 40					
IN 151	Continued From page		N	151			
		s during shift. No safety					
	precautions during sh						
		record revealed "Nursing					
	Notes," dated	at 2:09 PM revealing that					
		o the Nursing Office and restrained by staff last night.					
		eals there was no evidence					
	of documentation of a						
	Review of Resident #						
	evidence documentin						
		nded, by the end of the shift					
	in which it occurred a						
	In an interview condu	cted on at 2:21 PM,					
	the Staff I, Program N	flanager stated she was					
	notified immediately of	of the incident, was not at					
		irection to the Supervisors					
	and stated that there						
		ecause it was not completed					
	as per the PRTF's po						
	In an interview condu						
		sed Practical Nurse) stated					
	she assessed the res						
	the resident to the	he , and they sent					
		cted on at 2:09 PM.					
	Staff F, Floor Manage						
		on the 3:00 PM-11:00 PM					
		orted to Staff E, that Staff A,					
		ight before, 3 times. Staff D					
	called her and told he						
	instructed her to take	the resident to "Nursing"					
	and "I'm on my way. I	and another Manager					
	arrived at the facility,	interviewed Staff A who					
	admitted that he restr	ained the resident but didn't					
	call it in or notify anyo	one."					
	A review of the facility	s document titled					

"Correspondence" dated revealed, during morning 15-minute checks of "North Hallway," on Staff E noticed

		ID HUMAN SERVICES MEDICAID SERVICES					APPROVED 0. 0938-0391
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
			A. BUILD	NG	3		
						C	
		10L001	B. WING	_		05/	08/2019
NAME OF P	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
EL ODIDA	DALLES ADARESS				5925 MCKINLEY STREET		
FLORIDA	PALMS ACADEMY				HOLLYWOOD, FL 33021		
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	1D	_	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX		Y MUST BE PRECEDED BY FULL	PREF		(EACH CORRECTIVE ACTION SHOULD B		COMPLETION DATE
TAG	REGULATORY OR LSC IDENTIFYING INFORMATION)		TAG		CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE DATE	
					DE IGENOT)		
N 151	Continued From page	13	N	15	i1		
	that Resident #1 had	visible red marks to the					
	and . Resident #	1 stated Staff A restrained					
	him three times last n	ight. Staff A contacted Staff					
	F, advising her of the	incident taking place on					
		Staff A, stated, "I restrained					
	Resident #1 three tim	es last night."					
N 152	ORDERS FOR USE	OF OR	N	15	52		
	CFR(s): 483.358(h)(3	()					
		include] the time and					
		assessment required in					
	paragraph (f) of this s	ection.					
	This El EMENT is no	t met as evidenced by:					
	Based on review of the						
	Treatment Facility (PI						
		eview and interview, the					
		their own policies and					
		ent the results of the 1-hour					
		nd of the shift in which it					
		mpled residents (Resident					
	#1).	,					
	The findings included						
	Record review of the						
	" and Manu						
		on , reveals that the					
	use of manual	is limited to emergencies					
		inent risk of an individual					
		emselves, staff or others					
		rventions would not be					
		f documents the following					
	information by the en						
	occurred; the	order, the time the					

intervention began and ended, the time and

		ID HUMAN SERVICES					M APPROVED
	OF DEFICIENCIES	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(MAN MALE	TIEV P	CONCERNICATION	(X3) DATE	0. 0938-0391
	CORRECTION	IDENTIFICATION NUMBER:	A. BUILD		CONSTRUCTION	COMPLETE	
			A. BUILU			l .	С
		10L001	B. WING				08/2019
NAME OF P	ROVIDER OR SUPPLIER			- 5	TREET ADDRESS, CITY, STATE, ZIP CODE	1 03/	00/2019
TOURL OF T	NO FIDEN OF OUT FEET				925 MCKINLEY STREET		
FLORIDA	PALMS ACADEMY				OLLYWOOD, FL 33021		
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID.	_	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG		Y MUST BE PRECEDED BY FULL SC (DENTIFYING INFORMATION)	PREF TAG		(EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		COMPLETION DATE
N 152	Continued From page	e 14	N	152			
	results of theto-	assessment, the					
	emergency situation t	hat required the resident to					
	be restrained and the	name of staff involved in					
	the emergency safety						
		s Resident #1 was admitted					
	to the facility on	and discharged on					
		nade the resident eligible for					
		v of Resident #1's record ion that on on the					
		Mental Health Technician					
	(MHT) Shift Note," Re						
		te 100% of their meal and					
		uring mealtime. Took their					
	medication with no pr	oblem. Had positive					
	behaviors during shift	, interacted well with peers,					
	followed rules and sta	aff direction, had appropriate					
		em behaviors during shift.					
	No safety precautions						
		record revealed "Nursing					
	Notes," dated	at 2:09 PM revealing that					
		o the Nursing Office and restrained by staff last night.					
		eals there was no evidence					
	of documentation of a						
	Review of Resident #						
		tion related to the 1 hour					
		pleted by the end of the					
	shift in which it occurr	red, as required.					
	In an interview condu	cted on at 2:21 PM,					
		flanager stated she was					
		of the incident, was not at					
		irection to the Supervisors					
		is no " Packet"					
		ecause it was not completed					
	as per the PRTF's po	itcy. cted on at 2:53 PM					
	In an interview condu	cted on at 2:53 PM					

Staff G, a LPN (Licensed Practical Nurse) stated she assessed the resident on , called the Nurse Manager and the . . . . and they sent

DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND REAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING 101.001 R MING 05/08/2019 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 5925 MCKINLEY STREET FLORIDA PALMS ACADEMY HOLLYWOOD, FL 33021 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE DATE TAG REGULATORY OR LSC IDENTIFYING INFORMATION). TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) N 152 Continued From page 15 N 152 the resident to the ... In an interview conducted on at 2:09 PM. Staff F, Floor Manager states the incident on the 3:00 PM-11:00 PM shift, Resident #1 reported to Staff E, that Staff A. restrained them the night before, 3 times. Staff D. called her and told her about Resident #1. instructed her to take the resident to "Nursing"... and "I'm on my way. I and another Manager arrived at the facility, interviewed Staff A who admitted that he restrained the resident but didn't call it in or notify anyone." A review of the facility's document titled "Correspondence" dated revealed. during morning 15-minute checks of "North Hallway," on , Staff E noticed that Resident #1 had visible red marks to the . Resident #1 stated Staff A restrained him three times last night. Staff A contacted Staff F, advising her of the incident taking place on Resident #1 three times last night." N 153 ORDERS FOR USE OF OR N 153 CFR(s): 483.358(h)(4) [Documentation must include] the emergency safety situation that required the resident to be restrained or put in This ELEMENT is not met as evidenced by: Based on review of the Treatment Facility (PRTF)'s Policies and

Procedures, record review and interview, the PRTF failed to follow their own policies and procedures to document the emergency safety situation that required the resident to be

### PRINTED: 05/31/2019 DEPARTMENT OF HEALTH AND HUMAN SERVICES. ST

DEPARTMENT OF HEALTH AND HUMAN SERVICES						
CENTERS FOR MEDICARE & MEDICAID SERVICES CONTROL OF THE CONTROL OF T						
ATEMENT OF DEFICIENCIES ID PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING	(X3) DATE SURVEY COMPLETED			
			С			
	10L001	B. WING	05/08/2019			
MAKE OF PROVIDED OR CURRUIED		CERTET ADODESS SITV STATE TO SORE				

NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 5925 MCKINLEY STREET FLORIDA PALMS ACADEMY HOLLYWOOD, FL 33021 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION COMPLETION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE DATE TAG REGULATORY OR LSC IDENTIFYING INFORMATION). TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) N 153 Continued From page 16 N 153 restrained by the end of the shift in which it occurred for 1 of 3 sampled residents (Resident #1). The findings included: Record review of the facility's policy titled, and Manual Policy," dated and revised on ..... , reveals that the use of manual is limited to emergencies in which there is imminent risk of an individual physically harming themselves, staff or others and non-physical interventions would not be effective and that staff documents the following information by the end of the shift in which occurred; the order, the time the intervention began and ended, the time and results of the -toassessment, the

emergency situation that required the resident to be restrained and the name of staff involved in the emergency safety intervention. Record review reveals Resident #1 was admitted to the facility on ... and discharged on with diagnoses that made the resident eligible for the program. A review of Resident #1's record revealed documentation that on 3:00 PM-11:00 PM "Mental Health Technician (MHT) Shift Note," Resident #1 showered. brushed their ...., ate 100% of their meal and snack, no problems during mealtime. Took their medication with no problem. Had positive behaviors during shift, interacted well with peers. followed rules and staff direction, had appropriate boundaries. No problem behaviors during shift. No safety precautions during shift. Further review of the record revealed "Nursing at 2:09 PM revealing that Resident #1 came into the Nursing Office and

stated that they were restrained by staff last night.

ΔÞ

		ID HUMAN SERVICES MEDICAID SERVICES				FORM	M APPROVED 0. 0938-0391
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(V2) MUI	TIO	E CONSTRUCTION	(X3) DATE SURVEY	
	CORRECTION	IDENTIFICATION NUMBER:	A. BUILD			COMPLETED	
						1 6	c l
		10L001	B. WING				08/2019
NAME OF PE	ROVIDER OR SUPPLIER			П	STREET ADDRESS, CITY, STATE, ZIP CODE		
					5925 MCKINLEY STREET		
FLORIDA	PALMS ACADEMY				HOLLYWOOD, FL 33021		
(X4) ID	SUMMARY ST/	ATEMENT OF DEFICIENCIES	1D	_	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX		Y MUST BE PRECEDED BY FULL	PREF		(EACH CORRECTIVE ACTION SHOULD B		COMPLETION DATE
TAG	REGULATORT OR L	SC IDENTIFYING INFORMATION)	TAG		CROSS-REFERÊNCED TO THE APPROPRIA DEFICIENCY)	JE	UMIL.
			_				
N 153	Continued From page	17	NI.	153	3		
		eals there was no evidence	, ,,	100	"		
	of documentation of a						
	Review of Resident #						
		lion as to the reason of the					
		uation that required the					
		ned was completed, by the					
		ch it occurred as required.					
	In an interview condu	cted on at 2:21 PM,					
	the Staff I, Program N	flanager stated she was					
		of the incident, was not at					
		irection to the Supervisors					
	and stated that there						
		ecause it was not completed					
	as per the PRTF's pol	itcy. cted on at 2:53 PM,					
		sed Practical Nurse) stated					
		ident on called the					
	Nurse Manager and the						
	the resident to the						
	In an interview condu-						
	Staff F, Floor Manage	er states the incident					
	happened on	on the 3:00 PM-11:00 PM					
		orted to Staff E, that Staff A,					
		ight before, 3 times. Staff D					
	called her and told he						
		the resident to "Nursing"					
		and another Manager interviewed Staff A who					
		ained the resident but didn't					
	call it in or notify anyo						
	A review of the facility						
	"Correspondence" da						
	during morning 15-mi						
	Hallway," on	, Staff E noticed					
	that Resident #1 had	visible red marks to the					
	and . Resident #	1 stated Staff A restrained					
	him three times last n	ight. Staff A contacted Staff					

F, advising her of the incident taking place on ...., Staff A, stated, "I restrained

### PRINTED: 05/31/2019 DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED ST

CENTERS FOR MEDICARE & MEDICAID SERVICES C						
ATEMENT OF DEFICIENCIES ID PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		(X3) DATE SURVEY COMPLETED		
				С		
	10L001	B. WING		05/08/2019		
· · ·						

NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 5925 MCKINLEY STREET FLORIDA PALMS ACADEMY HOLLYWOOD, FL 33021 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION COMPLETION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE DATE TAG REGULATORY OR LSC IDENTIFYING INFORMATION). TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) N 153 Continued From page 18 N 153 Resident #1 three times last night." N 154 ORDERS FOR USE OF OR N 154 CFR(s): 483,358(h)(5) [Documentation must include] the name of staff involved in the emergency safety intervention. This ELEMENT is not met as evidenced by: Based on review of the Treatment Facility (PRTF)'s Policies and Procedures, record review and interview, the PRTF failed to follow their own policies and procedures to document the name of staff ., by the end of the shift in involved in the which it occurred for 1 of 3 sampled residents (Resident #1). The findings included: Record review of the facility's policy titled. and Manual Policy," dated , reveals that the and revised on use of manual is limited to emergencies in which there is imminent risk of an individual physically harming themselves, staff or others. and non-physical interventions would not be effective and that staff documents the following information by the end of the shift in which occurred: the order, the time the intervention began and ended, the time and results of the -toassessment, the emergency situation that required the resident to be restrained and the name of staff involved in the emergency safety intervention. Record review reveals Resident #1 was admitted to the facility on ... and discharged on

ΔÞ

DEPART	MENT OF HEALTH AN	ID HUMAN SERVICES					M APPROVED
CENTER	S FOR MEDICARE &	MEDICAID SERVICES				OMB N	D. 0938-0391
N 154 Continued From page with diagnoses that me the program. A review revealed documental 3:00 PM-11:00 PM 1% (MHT) Shift Note," Re brushed their a snack, no problems d medication with no problems of the Notes," dated Resident #1 came int stated that they were Continued review rev of documentation of a Review of Resident # evidence documentation of the shift in while in an interview conduct the Staff I. Program In notified immediately of the facility but gave of and stated that there available for review as per the PRTF's po	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		10L001	B. WING	_			C /08/2019
NAME OF P	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
					5925 MCKINLEY STREET		
FLORIDA	PALMS ACADEMY				HOLLYWOOD, FL 33021		
PREFIX	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
N 154	the program. A review revealed documental 3:00 PM-11:00 PM ** (MHT) Shift Note. *Re brushed their a snack, no problems d medication with no p behaviors during shift followed rules and staboundaries. No proble No safety precautions Further review of the Notes. ** dated Resident #1 came int stated that they were Continued review rev of documentation of a Review of Resident # stated that they were continued review revent of documentation of a Review of Resident # evidence documentation of the shift in whi an interview condute Staff I, Program A notified immediately of the facility but gave d and stated that there available for review b as per the PRTF's po In an interview condustaff G, a LPN (Licen she assessed the res she assessed the reserval.)	nade the resident eligible for vor Resident #1's record ion that on on the fental Health Technician sident #1's howered, te 100% of their meal and furthing mealtime. Took their oblem. Had positive in the foliation of their meal and furthing mealtime. Took their oblem. Had positive in the foliation of their oblem. Had positive in the foliation of their oblem. Had positive in the foliation of their oblem. Had positive and appropriate em behaviors during shift, studing shift, record revealed "Nursing at 2:09 PM revealing that to the Nursing Office and restrained by staff last night, easils there was no evidence are port of 1's record lacked any ion of the names of staff was completed, by the child to courred as required, ted on at 2:21 PM, danager stated she was of the incident, was not at irrection to the Supervisors is no "Packet" ecause it was not completed licy, cted on at 2:53 PM, sed Practical Nurse) stated	N	154			
	Staff F, Floor Manage	cted on at 2:09 PM, er states the incident on the 3:00 PM-11:00 PM					

shift, Resident #1 reported to Staff E, that Staff A, restrained them the night before, 3 times. Staff D

		D HUMAN SERVICES					PPROVED
STATEMENT (	S FOR MEDICARE & I OF DEFICIENCIES CORRECTION	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD	TIPLE CONSTRUCTION		(X3) DATE SUI COMPLET	RVEY
		10L001	B. WING			05/08/	2019
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CIT	TY, STATE, ZIP CODE		
FLORIDA	PALMS ACADEMY			5925 MCKINLEY STRI HOLLYWOOD, FL			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	SUMMAYS STATEMENT OF DEFICIENCIES  (DACH DEFICIENCY MUST AIR PRECEDED BY FULL  PRESIDENCY MUST AIR PRECEDED BY FULL  PRESIDENCY ON LSC IDENTIFYING THE OWNER			(X5) OMPLETION DATE		
N 154	called her and told he instructed her to take and "I'm on my way. I arrived at the facility, admitted that he restricall it in or notify any. A review of the facility. A review of the facility. "Correspondence" daduring morning 15-mil Haltway," on that Resident #1 had and Resident #1 had and Resident #1 had and Resident #1 had per of the Resident #3 had the resident #3 had the resident #3 had the resident #4 th	r about Resident #1. the resident to "Nursing" and another Manager interviewed Staff A who ained the resident but didn't resident but didn't resident to "Resident but didn't resident to the staff A resident resident and resident resident and resident resident staff A restrained resident staff A restrained resident staff A restrained resident staff A restrained resident staff resident resident staff resident resident staff resident reside		154			

to the facility on ... and discharged on with diagnoses that made the resident eligible for the program. A review of Resident #1's record

		ID HUMAN SERVICES MEDICAID SERVICES				FORM	D: 05/31/2019 M APPROVED D: 0938-0391
TATEMENT C	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		19L901	B. WING	_			C (08/2019
NAME OF PR	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
EI ODIDA	PALMS ACADEMY			5	925 MCKINLEY STREET		
FLORIDA	ACMS ACADEMI			۱	OLLYWOOD, FL 33021		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
N 155	3:00-11:00 PM Mental Shift Note, Resident 1, ate 100% of the problems during mea with no problem. Had shift, interacted well wand staff direction, ha No problem behavior precautions during she Further review of the Notes," dated Resident #1 came int stated that they were Continued review rev of documentation of Review of Resident # Review of Resident # stated that they were continued review rev of documentation of Review of Resident # evidence documentation that the properties of the use completed as required in an interview conduct the Staff i, Program in notified immediately of the facility but gave d and stated that there available for review b as per the PRTF's po In an interview conducts of the specific program interview conducts.	on that on on the I Health Technician (MHT) if I showered, brushed their iri meal and snack, no litime. Took their medication positive behaviors during vittin peers, followed rules of appropriate boundaries, siduring shift. No safety lift, record revealed "Nursing at 2:09 PM revealing that to the Nursing Office and restrained by staff last night, eals there was no evidence report of 1's record lacked any ion of the emergency safety tions used and their of a manual d. The safety of a manual d. The safety of the safe	N	155			
	Staff F, Floor Manage happened on	er states the incident on the 3:00 PM-11:00 PM					

shift, Resident #1 reported to Staff E, that Staff A, restrained them the night before, 3 times. Staff D called her and told her about Resident #1,

		ID HUMAN SERVICES MEDICAID SERVICES			PRINTED: 05/31/2019 FORM APPROVED OMB NO. 0938-0391		
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C A. BUILDING	ONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		10L001	B. WING		- 1	C (08/2019	
NAME OF P	ROVIDER OR SUPPLIER		STR	EET ADDRESS, CITY, STATE, ZIP CODE	1 05/	00,2015	
FLORIDA	PALMS ACADEMY		- 1	5 MCKINLEY STREET LLYWOOD, FL 33021			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE	
N 155	and "I'm on my way."  and "I'm on my way."  arrived at the facility, admitted that he restricall it in or notify and admitted that he restricted in the restriction of the facility "Correspondence" dading morning 15-mil Hallway." on that Resident #1 had and Resident #1 had and Resident #1 had and Resident #1 him three times last n F, advising her of the MONITORING DURIT CFR(s): 483.362(a)  Clinical staff trained in safety interventions in continually assessing and the safe use of of the emergency safe.  This STANDARD is in Based on review of the safe use of of the emergency safe the safe use of the resident Facility (P) Procedures, record re PRTF failed to follow procedures to continuonitor the physical of the resident for the	the resident to "Nursing" and another Manager interviewed Staff A who ained the resident but didn't ne." 's document titled ted revealed, nute checks of "North Staff E noticed visible red marks to the 1 stated Staff A restrained sight. Staff A contacted Staff incident taking place on Staff A, stated, "I restrained sight Staff A contacted Staff incident taking place on Staff A, stated," I restrained ses last night." NG AND AFTER  In the use of emergency nust be physically present, and monitoring the physical libeling of the resident and throughout the duration ely intervention.  The Residential RTF/S Policies and who wand interview, the their own policies and safe you safe you wand ally visually assess and and , well-being safe use of on of the for 1 of 3	N 155				

		ID HUMAN SERVICES					APPROVED
CENTER	S FOR MEDICARE &	MEDICAID SERVICES				OMB NO	0. 0938-0391
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		CONSTRUCTION	(X3) DATE COMP	SURVEY PLETED
							С
		10L001	B. WING	_		05/	08/2019
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
EI ODIDA	PALMS ACADEMY			5	925 MCKINLEY STREET		
FLORIDA	FALMS ACADEMI			۱	OLLYWOOD, FL 33021		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
N 165	Continued From page	. 23	N	165			
	The findings included		. "	100			
	The intumys included	•					
	Record review of the	facility's policy titled					
	" and Manu						
	and revised	on reveals that the					
	use of manual	is limited to emergencies					
	in which there is immi						
	physically harming the						
	and non-physical inte						
	effective and that staf						
		erventions shall be physically					
		lly visually assessing and					
	monitoring the physic						
		dent and the safe use of					
	throughout the emergency safety into	ne duration of the					
		s Resident #1 was admitted					
	to the facility on	and discharged on					
		nade the resident eligible for					
		v of Resident #1's record					
		ion that on on the					
		Mental Health Technician					
	(MHT) Shift Note," Re						
		te 100% of their meal and					
	snack, no problems d	uring mealtime. Took their					
	medication with no pr	oblem. Had positive					
		, interacted well with peers,					
	followed rules and sta	aff direction, had appropriate					
		em behaviors during shift.					
	No safety precautions						
		record revealed "Nursing					
	Notes," dated	at 2:09 PM revealing that					
		o the Nursing Office and					
		restrained by staff last night.					
		eals there was no evidence					
	of documentation of a	report of					

Review of Resident #1's record lacked any evidence documentation that the resident's physical and ..., . ... well-being was visually

DEPART	MENT OF HEALTH AN	ID HUMAN SERVICES				FORM	MAPPROVED	
CENTER	S FOR MEDICARE &	MEDICAID SERVICES				OMB NO. 0938-0391		
	DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED		
		10L001	B. WING			C 05/08/2019		
NAME OF P	ROVIDER OR SUPPLIER			П	STREET ADDRESS, CITY, STATE, ZIP CODE			
				ı	5925 MCKINLEY STREET			
FLORIDA	PALMS ACADEMY				HOLLYWOOD, FL 33021			
(X4) ID	TP VGAMMUP	ATEMENT OF DEFICIENCIES	1D	_	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX (EACH CORRECTIVE ACTION SHOULD BE C				COMPLETION DATE	
N 165	Continued From page	24	N	165	5			
		red during the and			-			
	throughout the duration							
	required.							
	In an interview condu	cted on at 2:21 PM,						
	the Staff I, Program N	Nanager stated she was						
		of the incident, was not at						
		irection to the Supervisors						
	and stated that there							
		ecause it was not completed						
	as per the PRTF's po	itcy. cted on at 2:53 PM,						
		sed Practical Nurse) stated						
		ident on						
	Nurse Manager and t							
	the resident to the							
	In an interview condu							
	Staff F, Floor Manage							
	happened on	on the 3:00 PM-11:00 PM						
	shift, Resident #1 rep	orted to Staff E, that Staff A,						
	restrained them the n	ight before, 3 times. Staff D						
	called her and told he							
		the resident to "Nursing"						
		and another Manager						
		interviewed Staff A who						
	call it in or notify anyo	ained the resident but didn't						
	A review of the facility							
	"Correspondence" da							
	during morning 15-mi							
	Hallway," on	, Staff E noticed						
		visible red marks to the						
		1 stated Staff A restrained						
	him three times last n	ight. Staff A contacted Staff						
	F, advising her of the	incident taking place on						
		Staff A, stated, "I restrained						
	Resident #1 three tim	es last night."						

N 167 MONITORING DURING AND AFTER

N 167

# DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 TYPERSHAM OF REPELIFIANCES AND REPORT SHAPEY TYPERSHAM OF REPELIFIANCES

CENTERS FOR MEDICARE &	MEDICAID SERVICES			OMB NO. 0938-039
FATEMENT OF DEFICIENCIES ND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDI	TIPLE CONSTRUCTION NG	(X3) DATE SURVEY COMPLETED
				С
	10L001	B. WING		05/08/2019
NAME OF PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	
EL ODIDA DALMO AGADEMY			5925 MCKINLEY STREET	
FLORIDA PALMS ACADEMY			HOLLYWOOD, FL 33021	

		102001		_		05/	08/2019
NAME OF P	ROVIDER OR SUPPLIER			Г	STREET ADDRESS, CITY, STATE, ZIP CODE		
EL ODIDA	DALMO ACADEMY			1	5925 MCKINLEY STREET		
FLOKIDA	PALMS ACADEMY				HOLLYWOOD, FL 33021		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SCIDENTIFYING INFORMATION)		ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD TAG CROSS-REFERENCE OT OTHE APPROPE DEFICIENCY)			(X5) COMPLETION DATE
N 167	the resident's well-bei emergency safety inte the resident's well-bei is removed.	icensed practitioner and the facility to evaluate ng and trained in the use of reventions, must evaluate ng immediately after the	N	16	7		
	Based on record revi Residential Treatment have a physician, or o evaluate the resident	Facility (PRTF) failed to ther licensed practitioner s well-being immediately moved for 1 of 3 sampled					
	to the facility on with diagnoses that m the program. A review revealed documentation at the program of the pro	Resident #1 was admitted and discharged on ade the resident eligible for of Resident #1's record on that on					

	MENT OF HEALTH AN S FOR MEDICARE & I					FORM	D: 05/31/2019 M APPROVED D: 0938-0391
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		E CONSTRUCTION	1	PLETED
		10L001	B. WING	_		1	C '08/2019
NAME OF P	ROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE		
				5	925 MCKINLEY STREET		
FLORIDA	PALMS ACADEMY			۱	HOLLYWOOD, FL 33021		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE
N 167	Continued From page of documentation of a Review of Resident #	report of	N	167			
	evidence of documen other licensed practiti resident's well-being i	tation that a physician or oner evaluated the mmediately after the					
	In an interview condu- the Staff I, Program N	d as required. cted on at 2:21 PM, fanager stated she was if the incident, was not at					
	the facility but gave d and stated that there	rection to the Supervisors is no " Packet" ecause it was not completed					
	as per the PRTF's po	icy.					
		sed Practical Nurse) stated					
	Nurse Manager and t the resident to the ,						
	Staff F, Floor Manage						
	shift, Resident #1 rep	on the 3:00 PM-11:00 PM orted to Staff E, that Staff A, ight before, 3 times. Staff D					
	called her and told he						
	arrived at the facility,	and another Manager interviewed Staff A who					
	call it in or notify anyo						
	A review of the facility "Correspondence" da during morning 15-mi	ted revealed,					
	Hallway," on	, Staff E noticed					
	and Resident #	1 stated Staff A restrained ight. Staff A contacted Staff					
	F, advising her of the	incident taking place on					

Resident #1 three times last night."

, Staff A, stated, "I restrained

## PRINTED: 05/31/2019 DEPARTMENT OF HEALTH AND HUMAN SERVICES

	WENT OF THE TENT	ID TIONS OF CENTICES				IWI APPROVED
CENTER	S FOR MEDICARE &	MEDICAID SERVICES			OMB N	O. 0938-0391
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDING	ONSTRUCTION		E SURVEY IPLETED
		10L001	B. WING		o:	C 5/08/2019
NAME OF P	ROVIDER OR SUPPLIER	•	STR	EET ADDRESS, CITY, STATE, ZIP CODE		
			5925	MCKINLEY STREET		
FLORIDA	PALMS ACADEMY		ног	LLYWOOD, FL 33021		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION]	ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
N 188	intervention and the I-do discussis include all staff involve when the presence o may jeopardize the w. Other staff and the reguardian(s) may part when it is deemed approximate the staff and the resident's pare. The discussion must and staff the opporture circumstances resulting and strateg.	the use of the or ed in an emergency safety esident must have a on. This discussion must ed in the intervention except fa ,	N 188			
	Based on review of t Treatment Facility (P Procedures, record of PRTF failed to condu (debriefing) after the involved in an emerg	RTF)'s Policies and eview and interview, the ct a to discussion use of a with staff encry safety intervention and hours for 1 of 3 sampled 11).				

... and revised on . use of manual is limited to emergencies

DEPART	MENT OF HEALTH AN	ID HUMAN SERVICES				FORM	APPROVED	
CENTER	S FOR MEDICARE &	MEDICAID SERVICES				OMB NO. 0938-0391		
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MUL	TIPE	LE CONSTRUCTION	(X3) DATE SURVEY		
AND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	A. BUILD	iNG		COMPLETED		
							С	
		10L001	B. WING	_		05/	08/2019	
NAME OF PR	ROVIDER OR SUPPLIER			Г	STREET ADDRESS, CITY, STATE, ZIP CODE			
EL ODIDA	PALMS ACADEMY				5925 MCKINLEY STREET			
FLORIDA	PALMS ACADEMI				HOLLYWOOD, FL 33021			
(X4) ID		ATEMENT OF DEFICIENCIES	1D	_	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX					(EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI		COMPLETION	
TAG	REGULATURT URT	SCIDENTIFTING INFORMATION)	TAG		DEFICIENCY)	ALE:	57.11.0	
			-					
N 188	C	- 20						
N 100	Continued From page		N	188	8			
		nent risk of an individual						
		emselves, staff or others,						
		rventions would not be						
		ty notifies and processes						
		ian of the resident who was nents the notification and						
		ided the notification and						
	within 24 hours post	the staff involved in						
	the intervention and t							
		n. which includes the staff						
	involved in the interve							
		s Resident #1 was admitted						
	to the facility on							
		ade the resident eligible for						
		of Resident #1's record						
	revealed documentati	on that on on the						
	3:00 PM-11:00 PM "N	fental Health Technician						
	(MHT) Shift Note," Re	sident #1 showered,						
	brushed their, a	te 100% of their meal and						
	snack, no problems d	uring mealtime. Took their						
	medication with no pr	oblem. Had positive						
	behaviors during shift	, interacted well with peers,						
		iff direction, had appropriate						
		em behaviors during shift.						
	No safety precautions							
		record revealed "Nursing						
		at 2:09 PM revealing that						
		o the Nursing Office and						
		restrained by staff last night.						
		eals there was no evidence						
	of documentation of a							
	Review of Resident #							
	evidence documentat							
	discussion (debriefing							
	with staff involved in a							
		esident within 24 hours was						
	conducted as require	d.						

In an interview conducted on

the Staff I, Program Manager stated she was

at 2:21 PM,

		D HUMAN SERVICES					APPROVED	
		MEDICAID SERVICES					. 0938-0391	
	DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		10L001	B. WING				08/2019	
NAME OF P	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		50,20.5	
				1	5925 MCKINLEY STREET			
FLORIDA	PALMS ACADEMY			1	HOLLYWOOD, FL 33021			
(X4) ID PREFIX TAG	X (EACH DEFICIENCY MUST BE PRECEDED BY FULL			ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)				
N 188	the facility but gave of and stated that there available for review b as per the PRTF's po an an interview condu Staff G, a LPN (Licen be assessed the res Nurse Manager and the resident to the in an interview condu Staff F, Floor Manager and the resident to the in an interview condu Staff F, Floor Manager and the resident of the interview condu Staff F, Floor Manager and the supposed on shift, Resident #1 represtrained them the n called her and told he instructed her to take and "I'm on my way. I arrived at the facility, admitted that he restrictly admitted that her sets call it in or notify anyc. A review of the facility "Correspondence" dad during morning 15-mit Hallway." on that Resident #1 had and Resident #1 him three times last not a suppose the suppose that the suppose the suppose that the suppose the suppose that the suppose that the suppose the suppose the suppose that the suppose the suppose the suppose that the suppose that the suppose that the suppose that the suppose the suppose that the suppose that the suppose the suppose that the suppose the suppose that the suppose that the suppose that the suppose that the suppose that the suppose that the suppose the suppose that the supp	if the incident, was not at rection to the Supervisors is no " Packet" ecause it was not completed licy, cted on at 2:53 PM, seed Practical Nurse) stated dent on called the he and they sent cted on at 2:09 PM, restates the incident on the 3:00 PM-11:00 PM orbit to Staff E, that Staff D, rabout Resident #1, the resident to "Nursing" and another Manager interviewed Staff A who aimed the resident but didn't ne." "Staff E noticed wisble red marks to the 1 stated Staff A restrained gifth. Staff A contacted Staff incident taking place on Staff A, stated, "I restrained staff incident taking place on Staff A, stated, "I restrained staff incident taking place on Staff A, stated, "I restrained staff incident taking place on Staff A, stated, "I restrained staff incident taking place on Staff A, stated, "I restrained staff incident taking place on Staff A, stated, "I restrained staff incident taking place on Staff A, stated, "I restrained staff incident taking place start night."		188	3			
		the use of or or or olved in the emergency appropriate supervisory						

and administrative staff, must conduct a

### PRINTED: 05/31/2019 DEPARTMENT OF HEALTH AND HUMAN SERVICES STA

DEPARTMENT OF HEALTH AND HUMAN SERVICES					
CENTERS FOR MEDICARE &	OMB NO. 0938-0391				
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING	(X3) DATE SURVEY COMPLETED		
			С		
	10L001	B. WING	05/08/2019		
NAME OF BROWINGS OF SUBBLIED		STREET ADDRESS CITY STATE ZIP CODE			

		10L001	B. WING _			C 05/08/2019
	ROVIDER OR SUPPLIER			5925	EET ADDRESS, CITY, STATE, ZIP CODE 5 MCKINLEY STREET LLYWOOD, FL 33021	00.00,20.12
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	(X5) COMPLETION E DATE
N 189	debriefing session that review and discussion 483.370(b)(1) The emthat required the inter-	at includes, at a minimum, a n of - ergency safety situation	N 1	89		
	Based on review of it Treatment Facility (PF Procedures, record re PRTF failed to follow! procedures to conduc includes a review and emergency safety situ intervention, including precipitating factors the within 24 hours after t staff involved in the er	RTF's Policies and view and interview, the their own policies and ta debriefing session that discussion of the ration that required the discussion of the ration that led up to the intervention he use of with all mergency safety opriate supervisory and				
	use of manual in which there is immi physically harming the and non-physical inter effective and that the	facility's policy titled, al Policy," dated on reveals that the is limited to emergencies nent risk of an individual amselves, staff or others rventions would not be facility staff involved in the s appropriate members of il conduct a debriefing				

Facility ID: RC57000049P

DEPART	MENT OF HEALTH AN	ID HUMAN SERVICES					APPROVED
CENTER	S FOR MEDICARE &	MEDICAID SERVICES				OMB NO	0. 0938-0391
STATEMENT OF DEFICIENCIES (X' AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDIN		LE CONSTRUCTION		PLETED
		10L001	B. WING				C '08/2019
NAME OF P	ROVIDER OR SUPPLIER			П	STREET ADDRESS, CITY, STATE, ZIP CODE		
					5925 MCKINLEY STREET		
FLORIDA	PALMS ACADEMY				HOLLYWOOD, FL 33021		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD & CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
N 189	Continued From page	31	N	189	9		
	to the facility on with diagnoses that in the program. A review revealed documents of the program of the progra	ade the resident eligible for vo of Resident #1's record on that on on the fental Health Technician sisted #1's howered. It 100% of their meal and uring mealtime. Took their oblem. Had positive interacted well with peers, iff direction, had appropriate mbehaviors during shift. Interacted word uring shift. Interacted word uring shift. It during shift					

as per the PRTF's policy.

In an interview conducted on ..... at 2:53 PM,

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES							FORM	05/31/2019 MAPPROVED 0. 0938-0391
STATEMENT C	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT		E CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		10L001	B. WING					08/2019
NAME OF PE	ROVIDER OR SUPPLIER			1	TREET ADDRESS, CITY, STATE, ZIP CODE			
FLORIDA I	PALMS ACADEMY			1	OLLYWOOD, FL 33021			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOI CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE		(X5) COMPLETION DATE
N 189	she assessed the res Nurse Manager and It the resident to the in an interview conduction Staff F, Floor Manage happened on shift, Resident #1 represtrained them the nealled her and told he instructed her to take and "I'm on my way. I arrived at the facility, admitted that he restrail it in or notify anyo A review of the facility of the staff	sed Practical Nurse) stated ident on called the he		189				

This ELEMENT is not met as evidenced by: Based on review of the Residential

### PRINTED: 05/31/2019 FORM APPROVED DEPARTMENT OF HEALTH AND HUMAN SERVICES STA

DENTERS FOR MEDICARE & MEDICAID SERVICES					
ATEMENT OF DEFICIENCIES D PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING	(X3) DATE SURVEY COMPLETED		
101.001		B. WING	С		
	102001		05/08/2019		

		10L001	B. WING	_		05/08	3/2019
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE				STREET ADDRESS, CITY, STATE, ZIP CODE			
FI ODIDA	D11 10 1010F107			1	5925 MCKINLEY STREET		
FLORIDA	PALMS ACADEMY			1	HOLLYWOOD, FL 33021		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
	Continued From page Treatment Facility (PF Procedures, record re PRTF failed to follow procedures to docum that both debriefing s changes to the reside result from the debrie residents (Resident # The findings included Record review of the "	TERMITEVING INFORMATION)  33  TTF'S Policies and viview and interview, the their own policies and ent in the resident's record essions took place and any nifs treatment plan that fings for 1 of 3 sampled 1).  (acility's policy titled, all policy, dated on reveals that the insert of the policy, dated on reveals that the insert of the policy in the pol	TAG		CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		DATE
	followed rules and sta boundaries. No proble No safety precautions Further review of the Notes," dated	, interacted well with peers, iff direction, had appropriate am behaviors during shift. during shift. ecord revealed "Nursing at 2:09 PM revealing that to the Nursing Office and					

		ID HUMAN SERVICES					M APPROVED
CENTER	S FOR MEDICARE &	MEDICAID SERVICES				OMB N	O. 0938-0391
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MUL A. BUILD		PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		10L001	B. WING			- 1	C i/08/2019
NAME OF PI	ROVIDER OR SUPPLIER			Г	STREET ADDRESS, CITY, STATE, ZIP CODE		
					5925 MCKINLEY STREET		
FLORIDA	PALMS ACADEMY				HOLLYWOOD, FL 33021		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
N 193	Continued From page	34	N	19	93		
	stated that they were	restrained by staff last night.					
		eals there was no evidence					1
	of documentation of a						
	Review of Resident#						1
		ion that both debriefing					
		and any changes to the					
	resident's treatment p	olan that result from the					
	debriefings was comp						
		cted on at 2:21 PM,					
		Manager stated she was					
		of the incident, was not at					
		irection to the Supervisors					
		is no " Packet"					
		ecause it was not completed					
	as per the PRTF's po In an interview condu						
		sed Practical Nurse) stated					
	she assessed the res						1
		he and they sent					
	the resident to the						
		cted on at 2:09 PM,					
	Staff F, Floor Manage						
	happened on	on the 3:00 PM-11:00 PM					
	shift, Resident #1 rep	orted to Staff E, that Staff A,					
	restrained them the n	ight before, 3 times. Staff D					
	called her and told he	er about Resident #1,					
		the resident to "Nursing"					
		and another Manager					
		interviewed Staff A who					
		ained the resident but didn't					
	call it in or notify anyo						
	A review of the facility						
		ited revealed,					
		nute checks of "North					
		visible red marks to the					
		1 stated Staff A restrained					
	and Residefil#	i otateu Otali A restrailee	1				

him three times last night. Staff A contacted Staff F, advising her of the incident taking place on

		ID HUMAN SERVICES MEDICAID SERVICES			FORM	05/31/2019 APPROVED 0938-0391
		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING	INSTRUCTION	(X3) DATE S COMPL	URVEY ETED
		10L001	B. WING		05/0	8/2019
NAME OF P	ROVIDER OR SUPPLIER		STRE	ET ADDRESS, CITY, STATE, ZIP CODE	1 03/0	0/2015
FLORIDA	PALMS ACADEMY		1	MCKINLEY STREET LYWOOD, FL 33021		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE
N 193		Staff A, stated, "I restrained	N 193			
N 196	MEDICAL TREATME CFR(s): 483.372(a)		N 196			
		ly obtain medical treatment I personnel for a resident an emergency safety				
	Based on review of the Treatment Facility (PI Procedures, record re PRTF failed to follow procedures to immed treatment from qualifications in resident injured as a life and the procedures to immed treatment from qualifications of the procedures to immed treatment from qualifications of the procedures and the procedures are the procedures and the procedures are the procedures are the procedures are the procedures are the procedures are the procedures are procedures are procedures procedur	eview and interview, the their own policies and				
	The findings included	:				
	use of manual in which there is immi physically harming his non-physical interven and that staff immedit treatment from qualific resident injured as a safety intervention. Record review reveal to the facility on	al Policy," dated on rovoals that the is limited to emergencies nent risk of an individual musel, staff or others, and titlor, would not be effective tately obtain medical ed medical personnel for a result of an emergency s Resident #1 was admitted				

the program. A review of Resident #1's record

		ID HUMAN SERVICES					M APPROVED
CENTER	S FOR MEDICARE &	MEDICAID SERVICES				OMR NO	0. 0938-0391
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MUL A. BUILD		LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		10L001	B. WING	_			C 08/2019
NAME OF PE	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
				1	5925 MCKINLEY STREET		
FLORIDA	PALMS ACADEMY			L	HOLLYWOOD, FL 33021		
(X4) ID		ATEMENT OF DEFICIENCIES	1D		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX		Y MUST BE PRECEDED BY FULL	PREF		(EACH CORRECTIVE ACTION SHOULD B		COMPLETION DATE
TAG	REGULATURT OR I	SC IDENTIFYING INFORMATION)	TAG	•	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(IE	
-							
N 196	Continued From page	36	N	19	36		
	, ,			10	~		
		ion that on on the					
		Mental Health Technician					
	(MHT) Shift Note," Re						
		te 100% of their meal and					
		luring mealtime. Took their					
	medication with no pr						
	behaviors during shift	, interacted well with peers,					
	followed rules and sta	aff direction, had appropriate					
	boundaries. No proble	em behaviors during shift.					
	No safety precautions	s during shift.					
	Further review of the	record revealed "Nursing					
	Notes," dated	at 2:09 PM revealing that					
	Resident #1 came int	o the Nursina Office with					
	multiple visible red m						
		they were restrained by staff					
		review reveals there was no					
	evidence of documen						
		nation of a report of					
	Review of Resident #	1's record lacked any					}
	evidence that immedi	ate medical attention after a					
	with injury w	as obtained for Resident #1.					
	In an interview condu						
		Manager stated she was					
		of the incident, was not at					
		irection to the Supervisors					
	and stated that there						
		ecause it was not completed					
	as per the PRTF's po						
		cted on at 2:53 PM.					
		sed Practical Nurse) stated					-
		ident on , called the					
	Nurse Manager and t						
	the resident to the						
	In an interview condu						
	Staff F, Floor Manage						
	happened on	on the 3:00 PM-11:00 PM					
		orted to Staff E, that Staff A,					{
	restrained them the n	ight before, 3 times. Staff D					

called her and told her about Resident #1,

### PRINTED: 05/31/2019 DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED STA

ENTERS FOR MEDICARE & MEDICAID SERVICES				
STEMENT OF DEFICIENCIES O PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING	(X3) DATE SURVEY COMPLETED	
	401.004	P Million	С	

10L001 05/08/2019 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE

5925 MCKINLEY STREET FLORIDA PALMS ACADEMY HOLLYWOOD, FL 33021 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE DATE TAG REGULATORY OR LSC IDENTIFYING INFORMATION). TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)

N 196

N 196 Continued From page 37 instructed her to take the resident to "Nursing"...

ΔNI

and "I'm on my way. I and another Manager arrived at the facility, interviewed Staff A who admitted that he restrained the resident but didn't call it in or notify anyone." A review of the facility's document titled "Correspondence" dated .... revealed.

during morning 15-minute checks of "North Hallway," on ...., Staff E noticed that Resident #1 had visible red marks to the and ... . Resident #1 stated Staff A restrained him three times last night. Staff A contacted Staff F, advising her of the incident taking place on

, Staff A, stated, "I restrained Resident #1 three times last night."